AMERICAN LUNG ASSOCIATION®
IN MICHIGAN

TO: **House Committee on Appropriations**

FROM: **Ken Fletcher, Director of Advocacy**

DATE: **May 2, 2018**

RE: **Opposition to Senate Bill 897/House Bill 5716 - Medicaid Work Requirements**

Thank you Chairwoman Cox and members of the committee. My name is Ken Fletcher and I am the Director of Advocacy for the American Lung Association in Michigan. I appreciate the opportunity to testify today on Senate Bill 897/House Bill 5716.

The American Lung Association is the oldest voluntary public health organization in the United States, representing 33 million Americans with lung disease including over 1.4 million in Michigan. For patients with lung disease, including asthma, COPD and lung cancer, having quality and affordable healthcare is essential.

These bills would create new and serious barriers to accessing healthcare by requiring people enrolled in the state's Medicaid program to either prove they work 30 hours per week or meet exemptions. If passed, this policy would jeopardize access to care for Michiganders. The American Lung Association in Michigan asks you to oppose this legislation.

Most people who get their healthcare coverage through Medicaid in Michigan and can work already do so.[1] A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[2] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. I would like to insert this study into the record for today's hearing.

A major consequence of these bills would be to increase the paperwork burden on all patients. Extensive administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they qualify for a modification or exemption. For example, after Washington State changed its Medicaid renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[3] In Michigan, the process of having to document exemptions from or compliance with the new requirements is similarly likely to create substantial administrative barriers to accessing or maintaining coverage. Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If someone forgets to report or misses a deadline twice, they would lose coverage for a year. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with health care providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Even enrollees who qualify for exemptions will have to provide documentation of their illness during the application and reassessment process, creating opportunities for administrative error that could jeopardize their coverage. No criteria can circumvent this problem and the serious risk to the health of the people we represent, who need continuous access to medical treatment.

Administering these requirements will also be expensive for the state of Michigan. The bill's fiscal note estimates that the administrative costs would range from $20 to $30 million dollars per year.[4] This would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of Michigan. Healthcare dollars should be used on delivering care, not creating bureaucratic red tape.

Many patient groups share our concerns that these bills will compromise individuals' access to care. I would like to submit a letter into the record signed by the American Lung Association in Michigan and other patient groups opposing this legislation.

The American Lung Association in Michigan urges you to oppose these bills and instead focus on solutions that can promote adequate, affordable and accessible coverage in Michigan's Medicaid program.

Thank you for your consideration.

Sincerely,

Kenneth R Fletcher

Kenneth Fletcher,
Director of Advocacy
Ken.fletcher@lung.org
248-220-5213

[1] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[2] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055
[3] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.
[4] http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf

Letters

RESEARCH LETTER

HEALTH CARE REFORM

Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan

The Affordable Care Act (ACA) expanded Medicaid coverage to approximately 11 million working-age adults. Critics have raised concerns about providing Medicaid to adults capable of working. Several states have proposed work requirements in Section 1115 Medicaid waivers.[1,2] Although none were approved during the Obama administration, the Trump administration is willing to consider such provisions.[3] Prior analyses[4] estimated that half of adults eligible for ACA Medicaid expansion were employed, and 62% of nondisabled adults were working or in school. Although these national estimates of Medicaid-eligible individuals are valuable, less is known about the employment experience of actual enrollees in Medicaid expansion states and which health characteristics may keep them from working. Complementary state-level analyses are needed as individual states consider whether to propose work requirements. This study examined the demographic and health characteristics associated with the employment status of current Medicaid expansion enrollees in Michigan, which expanded Medicaid under a Section 1115 waiver to nonelderly adults with incomes at or below 133% of the federal poverty level who do not otherwise qualify for Medicaid or Medicare based on disability or other criteria.[5]

Methods | The study was deemed to be exempt from approval by the institutional review boards of the University of Michigan and Michigan Department of Health and Human Services. All survey participants provided verbal consent. From January 1 through October 31, 2016, we conducted a computer-assisted telephone survey in English, Arabic, and Spanish of Medicaid expansion (Healthy Michigan Plan) enrollees with at least 12 months of coverage (response rate, 54%). Sampling was stratified by income and Michigan region. Measures included demographic and health characteristics. Multivariable logistic regression analysis incorporating sampling and nonresponse weights were used to examine the association between demographic and health characteristics and the outcomes of being out of work or unable to work vs employed, adjusting for age, sex, race, health status, presence of chronic health conditions, and functional limitations. Analyses were conducted using Stata software (version 14.2; StataCorp). Two-sided $P < .05$ was considered to be significant.

Results | Among 4090 surveyed Healthy Michigan Plan enrollees (weighted sample, 379 627; 48.4% male and 51.6% female; mean [SD] age, 40.36 [12.96] years), 48.8% reported that they were employed or self-employed; 27.6% were out of work, 11.3% were unable to work, 2.5% were retired, 5.2% were students, and 4.5% were homemakers. **Table 1** presents demographic and health characteristics of enrollees out of work or unable to work compared with employed enrollees. In multivariable analyses (**Table 2**), enrollees were more likely to report being out of work if they were older, male, African American, or in fair or poor health or had mental health conditions or functional limitations. Enrollees were more likely to report being unable to work if they were older, male, or in fair or poor health or had chronic health conditions or functional limitations.

Discussion | Our findings have key implications for proposed work requirement policies for Medicaid expansion enrollees. First, more than half of Michigan enrollees were already working or students and thus would not be affected by work requirements. Second, most enrollees who were unable to work reported significant barriers to employment, such as poor health, chronic conditions, older age, or functional limitations. Work requirements could disrupt coverage for such vulnerable individuals who may not meet formal criteria for disability. Third, although those who were out of work reported better health and fewer functional limitations, the proportion of Medicaid expansion enrollees overall who were not working and possibly able to work if employment were available remained small. Study limitations include self-reported outcomes, single state data, and lack of information about whether enrollees were looking for work or had other barriers, such as caregiving responsibilities (thus, the proportion of those not working or looking for work may be lower than our estimates). States should consider the administrative costs of implementing a work requirement program to identify and enforce employment for relatively few individuals and the risk of coverage interruptions for vulnerable individuals with chronic health conditions.

Renuka Tipirneni, MD, MSc
Susan D. Goold, MD, MHSA, MA
John Z. Ayanian, MD, MPP

Author Affiliations: Division of General Medicine, Department of Internal Medicine, University of Michigan Medical School, Ann Arbor (Tipirneni, Goold, Ayanian); Institute for Healthcare Policy and Innovation, University of Michigan, Ann Arbor (Tipirneni, Goold, Ayanian); Department of Health Management and Policy, School of Public Health, University of Michigan, Ann Arbor (Goold, Ayanian); Gerald R. Ford School of Public Policy, University of Michigan, Ann Arbor (Ayanian).

Corresponding Author: Renuka Tipirneni, MD, MSc, Division of General Medicine, Department of Internal Medicine, University of Michigan Medical School, North Campus Research Complex, Building 16, Room 419W, 2800 Plymouth Rd, Ann Arbor, MI 48109 (rtipirne@med.umich.edu).

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Table 1. Demographic and Health Characteristics for Michigan Medicaid Expansion Enrollees by Employment Status

Enrollee Respondent Characteristic	Employment Status, Weighted % (95% CI)[a]			P Value[b]	Total Weighted Sample, % (95% CI) (n = 379 627)
	Out of Work (n = 104 534)	Unable to Work (n = 42 720)	Employed (n = 185 435)		
Age, y					
19-34	34.8 (30.9-38.9)	14.8 (10.6-20.2)	45.8 (43.0-48.6)	<.001	39.9 (37.9-41.9)
35-50	37.7 (33.8-41.8)	43.1 (37.6-48.8)	34.2 (31.6-36.8)		34.0 (32.2-36.0)
51-64	27.5 (24.4-30.8)	42.1 (36.8-47.5)	20.0 (18.3-21.9)		26.1 (24.6-27.6)
Male	57.2 (53.3-61.1)	53.9 (48.3-59.4)	45.5 (42.7-48.3)	<.001	48.4 (46.5-50.4)
Race					
White	55.2 (51.1-59.2)	70.3 (64.7-75.4)	62.2 (59.5-64.9)	<.001	61.3 (59.4-63.2)
Black or African American	34.4 (30.6-38.5)	21.9 (17.3-27.3)	24.2 (21.8-26.8)		25.9 (24.2-27.7)
Other	5.9 (4.4-7.9)	4.3 (2.5-7.3)	9.4 (7.9-11.2)		8.8 (7.7-10.0)
>1 Race	4.4 (3.0-6.5)	3.6 (2.1-6.1)	4.1 (3.1-5.5)		4.0 (3.3-4.9)
Ethnicity					
Hispanic or Latino	4.6 (3.1-6.6)	3.3 (1.8-6.0)	6.1 (4.9-7.6)	.43	5.2 (4.4-6.2)
Arab, Chaldean, or Middle Eastern	2.7 (1.7-4.1)	1.2 (0.3-4.8)	7.3 (5.9-9.0)	<.001	6.2 (5.3-7.2)
Income, % federal poverty level					
0%-35%	79.1 (76.5-81.5)	73.8 (69.4-77.8)	33.7 (31.3-36.3)	<.001	51.7 (50.7-52.7)
36%-99%	15.0 (12.9-17.3)	13.9 (10.9-17.6)	38.1 (36.1-40.1)		28.5 (27.6-29.3)
≥100%	5.9 (4.7-7.4)	12.2 (9.6-15.4)	28.1 (26.5-29.8)		19.8 (19.2-20.5)
Veteran	3.9 (2.6-5.8)	5.9 (3.7-9.2)	2.3 (1.6-3.3)	.001	3.4 (2.7-4.2)
Health status					
Excellent, very good, or good	66.1 (62.3-69.6)	26.2 (21.5-31.5)	80.3 (78.1-82.4)	<.001	70.1 (68.4-71.9)
Fair or poor	33.7 (30.1-37.4)	73.4 (68.1-78.1)	19.6 (17.5-21.9)		29.7 (28.0-31.5)
Chronic health condition	74.0 (69.9-77.6)	94.0 (90.6-96.2)	62.3 (59.5-65.0)	<.001	69.2 (67.3-71.0)
Physical health condition	65.1 (60.9-69.0)	87.5 (82.6-91.2)	53.8 (51.0-56.6)	<.001	60.8 (58.8-62.8)
Diabetes	11.4 (9.3-13.9)	22.3 (17.9-27.4)	8.8 (7.5-10.4)	<.001	10.8 (9.7-12.1)
Hypertension	37.6 (33.8-41.5)	54.2 (48.5-59.8)	24.9 (22.7-27.3)	<.001	31.3 (29.6-33.1)
Cardiovascular disease	10.4 (8.2-13.2)	22.9 (18.3-28.2)	7.1 (5.9-8.6)	<.001	9.8 (8.7-11.0)
Asthma	16.1 (13.5-19.1)	26.6 (21.9-31.9)	14.7 (12.9-16.6)	<.001	17.1 (15.7-18.6)
COPD	11.2 (9.2-13.6)	23.7 (19.3-28.8)	7.6 (6.2-9.1)	<.001	10.5 (9.5-11.7)
Cancer	2.7 (1.8-4.1)	10.2 (7.4-14.0)	2.8 (2.1-3.6)	<.001	3.7 (3.2-4.4)
Mental health condition	35.3 (31.7-39.1)	61.7 (56.1-66.9)	25.2 (22.9-27.7)	<.001	32.2 (30.4-34.0)
Mood disorder	33.7 (30.1-37.4)	59.6 (54.1-65.0)	23.5 (21.2-25.9)	<.001	30.5 (28.7-32.3)
Other	0.2 (0.0-1.1)	1.2 (0.5-2.8)	0.8 (0.4-1.8)	.008	0.8 (0.4-1.3)
Functional impairment (≥14 of past 30 d)					
Physical	24.4 (21.2-27.9)	68.8 (63.2-73.8)	13.3 (11.6-15.3)	<.001	22.9 (21.3-24.5)
Mental	25.0 (21.7-28.7)	48.4 (42.7-54.1)	11.6 (10.1-13.4)	<.001	19.9 (18.3-21.5)

[a] Numbers in column heads indicate weighted numbers for the population.

[b] Generated from χ^2 analyses that included all categories of employment, including employed or self-employed, out of work, unable to work, homemaker, student, and retired.

Study concept and design: All authors.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Tipirneni.
Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: Tipirneni, Goold.
Obtained funding: All authors.
Study supervision: All authors.

Conflict of Interest Disclosures: None reported.

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Table 2. Multivariable Logistic Regression Analysis of Association Between Michigan Medicaid Expansion Enrollee Demographic and Health Characteristics and Being Out of Work or Unable to Work

	Employment Outcomes[a]			
	Out of Work		Unable to Work	
Characteristic	AOR (95% CI)	*P* Value[b]	AOR (95% CI)	*P* Value[b]
Age, y				
19-34	1 [Reference]	NA	1 [Reference]	NA
35-50	1.29 (0.99-1.67)	.06	2.34 (1.45-3.75)	<.001
51-64	1.67 (1.29-2.17)	<.001	4.20 (2.64-6.65)	<.001
Male (reference, female)	1.80 (1.45-2.23)	<.001	1.88 (1.35-2.63)	<.001
Race				
White	1 [Reference]	NA	1 [Reference]	NA
Black or African American	1.93 (1.50-2.49)	<.001	1.16 (0.76-1.78)	.48
Other	0.75 (0.50-1.11)	.15	0.51 (0.25-1.06)	.07
>1 Race	1.25 (0.72-2.18)	.42	1.02 (0.49-2.15)	.95
Fair or poor health	1.47 (1.15-1.89)	.003	3.52 (2.42-5.11)	<.001
Chronic health condition (reference, none)				
Physical	1.11 (0.88-1.42)	.38	1.73 (1.08-2.79)	.02
Mental	1.47 (1.16-1.87)	.001	2.61 (1.82-3.73)	<.001
Functional limitation (reference, none)				
Physical	1.43 (1.07-1.92)	.02	5.10 (3.54-7.33)	<.001
Mental	1.95 (1.46-2.60)	<.001	2.29 (1.56-3.37)	<.001

Abbreviation: AOR, adjusted odd ratio.

[a] Each column represents a different multivariable logistic regression model relative to the reference category of employed enrollees.

[b] Generated from multivariable logistic regression incorporating sampling and nonresponse weights and adjusted for age, sex, race, health status, presence of chronic health conditions, and functional limitations.

the University of Michigan Center for Value-Based Insurance Design, provided thoughtful comments on earlier drafts of this manuscript. He was not compensated for his contribution.

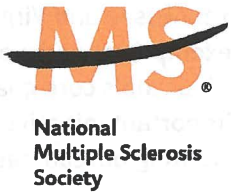
1. Musumeci M. Medicaid and work requirements. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/medicaid-and-work-requirements. March 23, 2017. Accessed September 29, 2017.

2. Garfield R, Rudowitz R, Damico A. Understanding the intersection of Medicaid and work. Kaiser Family Foundation. http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work. February 15, 2017. Accessed September 29, 2017.

3. Price TE, Verma S. *Letter to the Nation's Governors*. Washington, DC: US Department of Health and Human Services; 2017. https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf. Accessed September 29, 2017.

4. Ku L, Brantley E. Myths about the Medicaid expansion and the "able-bodied." Health Affairs Blog. http://healthaffairs.org/blog/2017/03/06/myths-about-the-medicaid-expansion-and-the-able-bodied. March 6, 2017. Accessed September 29, 2017.

5. Ayanian JZ. Michigan's approach to Medicaid expansion and reform. *N Engl J Med*. 2013;369(19):1773-1775.



April 23, 2018

Our organizations represent millions of patients and their families facing serious health conditions and are committed to ensuring they have adequate, affordable and accessible health care coverage at every stage of life. We write to express our deep concern with Senate Bill 897 and House Bill 5716. This legislation would create new and serious barriers to accessing healthcare by requiring people enrolled in the state's Medicaid program to either prove they work 30 hours per week or meet exemptions. If passed, this policy would jeopardize access to care for Michiganders. Our organizations ask you to oppose SB897 and HB5716.

The bill requires the Michigan Department of Health and Human Services to apply for a section 1115 Waiver from the federal government to implement this requirement. A major consequence of SB897 and HB5716 would be to increase the paperwork burden on all patients. Extensive administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they qualify for a modification or exemption. For example, after Washington State changed its Medicaid renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[i] In Michigan, the process of having to document exemptions from or compliance with the new requirements is similarly likely to create substantial administrative barriers to accessing or maintaining coverage. Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases. If someone forgets to report or misses a deadline twice, they would lose coverage for a year. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with health care providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Even enrollees who qualify for exemptions will have to provide documentation of their illness during the application and reassessment process, creating opportunities for administrative error that could jeopardize their coverage. No criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will also be expensive for the state of Michigan. States such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[ii] This would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of Michigan. Healthcare dollars should be used on delivering care, not creating bureaucratic red tape.

Ultimately, SB897 and HB5716 will not help low-income families improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[iii] A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[iv] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

We urge you to oppose this legislation and instead focus on solutions that can promote adequate, affordable and accessible coverage in Michigan's Medicaid program.

Sincerely,

American Cancer Society- Cancer Action Network
American Diabetes Association
American Heart Association
American Lung Association
Arthritis Foundation
Cystic Fibrosis Foundation
Leukemia & Lymphoma Society
National Multiple Sclerosis Society
National Organization of Rare Diseases

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[i] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[ii] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018. Available at https://www.rollcall.com/news/politics/medicaid-kentucky.

[iii] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[iv] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055